105TH CONGRESS
2D SESSION

S. 2416

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

IN THE SENATE OF THE UNITED STATES

JULY 31, 1998

Mr. CHAFEE (for himself, Mr. GRAHAM, Mr. LIEBERMAN, Mr. SPECTER, and Mr. BAUCUS) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Promoting Responsible Managed Care Act of 1998''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—The provisions of section 2971 of the Public Health Service Act shall apply for purposes of this section, section 3, and title I in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, for purposes of this section and title I, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the Secretary of the Treasury, and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out title I under sections 2706 and 2751 of the Public Health Service Act, the Secretary of Labor in relation to carrying out title I under section 713 of the Employee Retirement Income Security Act of 1974, and the Secretary of the Treasury in relation to carrying out title I under chapter 100 and section 4980D of the Internal Revenue Code of 1986.

(c) ADDITIONAL DEFINITIONS.—For purposes of this section and title I:

(1) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of title I, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such specific provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

(2) CLINICAL PEER.—The term ''clinical peer'' means, with respect to a review or appeal, a physician (allopathic or osteopathic) or other health care professional who holds a non-restricted license in a State and who is appropriately credentialed, licensed, certified, or accredited in the same or similar specialty as manages (or typically manages) the medical condition, procedure, or treatment under review or appeal and includes a pediatric specialist where appropriate; except that only a physician may

be a clinical peer with respect to the review or appeal of treatment rendered by a physician.

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional provider of health care services.

(4) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(5) PARTICIPATING.—The term ''participating'' mean, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

SEC. 3. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), title I shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of such title.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in title I shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(3) CONSTRUCTION WITH RESPECT TO TIME PERIODS.—Subject to paragraph (2), nothing in title I shall be construed to prohibit a State from establishing, implementing, or continuing in effect any requirement or standard that uses a shorter period of time, than that provided under such title, for any internal or external appeals process to be used by health insurance issuers.

(b) RULES OF CONSTRUCTION.—Nothing in title I (other than section 128) shall be construed as requiring

a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

(c) DEFINITIONS.—For purposes of this section:

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) INCLUSION OF POLITICAL SUBDIVISIONS OF A STATE.—The term ''State'' also includes any political subdivisions of a State or any agency or instrumentality thereof.

(d) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

(1) IN GENERAL.—Nothing in this Act (or the amendments made thereby) shall be construed to—

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage in connection with group health plans, to include as providers religious nonmedical providers;

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers;

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals from decisions denying or limiting coverage for care by religious nonmedical providers; or

(iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider; or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

(2) RELIGIOUS NONMEDICAL PROVIDER.—For purposes of this subsection, the term ''religious nonmedical provider'' means a provider who provides no

medical care but who provides only religious non-medical treatment or religious nonmedical nursing care.

SEC. 4. REGULATIONS.

The Secretaries of Health and Human Services, Labor, and the Treasury shall issue such regulations as may be necessary or appropriate to carry out this Act. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this Act.

TITLE I—PROMOTING RESPONSIBLE MANAGED CARE

Subtitle A—Grievance and Appeals

SEC. 101. DEFINITIONS AND GENERAL PROVISIONS RELATING TO GRIEVANCE AND APPEALS.

(a) DEFINITIONS.—In this subtitle:

(1) AUTHORIZED REPRESENTATIVE.—The term ''authorized representative'' means, with respect to a covered individual, an individual who—

(A) is—

(i) any treating health care professional of the covered individual (acting within the scope of the professional's li-

cense or certification under applicable State law), or

(ii) any legal representative of the covered individual (or, in the case of a deceased individual, the legal representative of the estate of the individual),

regardless of whether such professional or representative is affiliated with the plan or issuer involved; and

(B) is acting on behalf of the covered individual with the individual's consent.

(2) COVERAGE DETERMINATION.—The term ''coverage determination'' means a determination by a group health plan or a health insurance issuer with respect to any of the following:

(A) A decision whether to pay for emergency services (as defined in section 121(a)(2)(B)).

(B) A decision whether to pay for health care services not described in subparagraph (A) that are furnished by a provider that is a participating health care provider with the plan or issuer.

(C) A decision whether to provide benefits or payment for such benefits.

(D) A decision whether to discontinue a benefit.

(E) A decision resulting from the application of utilization review (as defined in section 102(a)(1)(C)).

Such term includes, pursuant to section 104(d)(2), the failure to provide timely notice under section 104(d).

(3) COVERED INDIVIDUAL.—The term ''covered individual'' means an individual who is a participant or beneficiary in a group health plan or an enrollee in health insurance coverage offered by a health insurance issuer.

(4) GRIEVANCE.—The term ''grievance'' means any complaint or dispute other than one involving a coverage determination.

(5) RECONSIDERATION.—The term ''reconsideration'' is defined in section 105(a)(7).

(6) UTILIZATION REVIEW.—The term ''utilization review'' is defined in section 102(a)(1)(C).

(b) SUMMARY OF RIGHTS OF INDIVIDUALS.—In accordance with the provisions of this subtitle, a covered individual has the following rights with respect to a group health plan and with respect to a health insurance issuer in connection with the provision of health insurance coverage:

(1) The right to have grievances between the covered individual and the plan or issuer heard and resolved as provided in section 103.

(2) The right to a timely coverage determination as provided in section 104.

(3) The right to request expedited treatment of a coverage determination as provided in section 104(c).

(4) If dissatisfied with any part of a coverage determination, the following appeal rights:

(A) The right to a timely reconsideration of an adverse coverage determination as provided in section 105.

(B) The right to request expedited treatment of such a reconsideration as provided in section 105(c).

(C) If, as a result of a reconsideration of the adverse coverage determination, the plan or issuer affirms, in whole or in part, its adverse coverage determination, the right to request and receive a review of, and decision on, such determination by a qualified external appeal entity as provided in section 106.

(c) REQUIREMENTS.—

(1) PROCEDURES.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage shall, with respect to the provision of benefits under such plan or coverage—

(A) establish and maintain—

(i) grievance procedures in accordance with section 103;

(ii) procedures for coverage determinations consistent with section 104; and

(iii) appeals procedures for adverse coverage determinations in accordance with sections 105 and 106; and

(B) provide for utilization review consistent with section 102.

(2) DELEGATION.—A group health plan or a health insurance issuer in connection with the provision of health insurance coverage that delegates any of its responsibilities under this subtitle to another entity or individual through which the plan or issuer provides health care services shall ultimately be responsible for ensuring that such entity or individual satisfies the relevant requirements of this subtitle.

SEC. 102. UTILIZATION REVIEW ACTIVITIES.

(a) IN GENERAL.—

(1) COMPLIANCE WITH REQUIREMENTS.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

(B) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(C) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concur-

rent review, second opinions, case management, discharge planning, or retrospective review.

(2) WRITTEN POLICIES AND CRITERIA.—

(A) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

(B) USE OF WRITTEN CRITERIA.—

(i) IN GENERAL.—Such a program shall utilize written clinical review criteria developed pursuant to the program with the input of appropriate physicians. Such criteria shall include written clinical review criteria described in section 114(b)(4)(B).

(ii) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for a covered individual under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the individual during the same course of treatment.

(3) CONDUCT OF PROGRAM ACTIVITIES.—

(A) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—

(i) IN GENERAL.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(ii) HEALTH CARE PROFESSIONAL DEFINED.—In this subsection, the term ''health care professional'' means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.

(B) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(i) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and, to the extent required, who have received appropriate training in the conduct of such activities under the program.

(ii) PEER REVIEW OF SAMPLE OF ADVERSE CLINICAL DETERMINATIONS.—Such

a program shall provide that clinical peers (as defined in section 2(c)(2)) shall evaluate the clinical appropriateness of at least a sample of adverse clinical determinations.

(iii) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that—

(I) provides direct or indirect incentives for such persons to make inappropriate review decisions; or

(II) is based, directly or indirectly, on the quantity or type of adverse determinations rendered.

(iv) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who provides health care services to a covered individual to perform utilization review activities in connection with the health care services being provided to the individual. A group health plan, or a health insurance issuer in con-

nection with the provision of health insurance coverage, may not retaliate against a covered individual or health care provider based on such individual's or provider's use of, or participation in, the utilization review program under this section.

(C) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

(D) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to a covered individual more frequently than is reasonably required to assess whether the services under review are medically necessary or appropriate.

(E) LIMITATION ON INFORMATION REQUESTS.—Such a program shall provide that information shall be required to be provided by

health care providers only to the extent it is necessary to perform the utilization review activity involved.

(F) REVIEW OF PRELIMINARY UTILIZATION REVIEW DECISION.—Such a program shall provide that a covered individual who is dissatisfied with a preliminary utilization review decision has the opportunity to discuss the decision with, and have such decision reviewed by, the medical director of the plan or issuer involved (or the director's designee) who has the authority to reverse the decision.

(b) STANDARDS RELATING TO MEDICAL DECISION MAKING.—

(1) IN GENERAL.—In providing for a coverage determination in the process of carrying out utilization review, a group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, may not arbitrarily interfere with or alter the decision of the treating physician if the services are medically necessary or appropriate for treatment or diagnosis to the extent that such treatment or diagnosis is otherwise a covered benefit.

(2) CONSTRUCTION.—Paragraph (1) shall not be construed as prohibiting a plan or issuer from limiting the delivery of services to one or more health care providers within a network of such providers.

(3) NO CHANGE IN COVERAGE.—Paragraph (1) shall not be construed as requiring coverage of particular services the coverage of which is otherwise not covered under the terms of the plan or coverage or from conducting utilization review activities consistent with this section.

(4) MEDICAL NECESSITY OR APPROPRIATENESS DEFINED.—In paragraph (1), the term ''medically necessary or appropriate'' means, with respect to a service or benefit, a service or benefit which is consistent with generally accepted principles of professional medical practice.

SEC. 103. ESTABLISHMENT OF PROCESS FOR GRIEVANCES.

(a) ESTABLISHMENT.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall provide meaningful procedures for timely hearing and resolution of grievances brought by covered individuals regarding any aspect of the plan's or issuer's services, including a decision not to expe-

dite a coverage determination or reconsideration under section 104(c)(4)(B)(ii)(II) or 105(c)(4)(B)(ii)(II).

(b) GUIDELINES.—The grievance procedures required under subsection (a) shall meet all guidelines established by the appropriate Secretary.

(c) DISTINGUISHED FROM COVERAGE DETERMINATIONS AND APPEALS.—The grievance procedures required under subsection (a) shall be separate and distinct from procedures regarding coverage determinations under section 104 and reconsiderations under section 105 and external reviews by a qualified external appeal entity under section 106 (which address appeals of coverage determinations).

SEC. 104. COVERAGE DETERMINATIONS.

(a) REQUIREMENT.—

(1) RESPONSIBILITIES.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain procedures for making timely coverage determinations (in accordance with the requirements of this section) regarding the benefits a covered individual is entitled to receive from the plan or issuer, including the amount of any copayments, deductibles, or other cost sharing applicable to such benefits. Under this section, the plan or issuer shall

have a standard procedure for making such determinations, and procedures for expediting such determinations in cases in which application of the standard deadlines could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(2) PARTIES WHO MAY REQUEST COVERAGE DETERMINATIONS.—Any of the following may request a coverage determination relating to a covered individual and are parties to such determination:

(A) The covered individual and an authorized representative of the individual.

(B) A health care provider who has furnished an item or service to the individual and formally agrees to waive any right to payment directly from the individual for that item or service.

(C) Any other provider or entity (other than the group health plan or health insurance issuer) determined by the appropriate Secretary to have an appealable interest in the determination.

(3) EFFECT OF COVERAGE DETERMINATION.—A coverage determination is binding on all parties

unless it is reconsidered pursuant to section 105 or reviewed pursuant to section 106.

(b) DETERMINATION BY DEADLINE.—

(1) IN GENERAL.—In the case of a request for a coverage determination, the group health plan or health insurance issuer shall provide notice pursuant to subsection (d) to the person submitting the request of its determination as expeditiously as the health condition of the covered individual involved requires, but in no case later than deadline established under paragraph (2) or, if a request for expedited treatment of a coverage determination is granted under subsection (c), the deadline established under paragraph (3).

(2) STANDARD DEADLINE.—

(A) IN GENERAL.—The deadline established under this paragraph is, subject to subparagraph (B), 14 calendar days after the date the plan or issuer receives the request for the coverage determination.

(B) EXTENSION.—The plan or issuer may extend the deadline under subparagraph (A) by up to 14 calendar days if—

(i) the covered individual (or an authorized representative of the individual) requests the extension; or

(ii) the plan or issuer justifies to the applicable authority a need for additional information to make the coverage determination and how the delay is in the interest of the covered individual.

(3) EXPEDITED TREATMENT DEADLINE.—

(A) IN GENERAL.—The deadline established under this paragraph is, subject to subparagraphs (B) and (C), 72 hours after the date the plan or issuer receives the request for the expedited treatment under subsection (c).

(B) EXTENSION.—The plan or issuer may extend the deadline under subparagraph (A) by up to 5 calendar days if—

(i) the covered individual (or an authorized representative of the individual) requests the extension; or

(ii) the plan or issuer justifies to the applicable authority a need for additional information to make the coverage determination and how the delay is in the interest of the covered individual.

(C) HOW INFORMATION FROM NONPARTICIPATING PROVIDERS AFFECTS DEADLINES FOR EXPEDITED COVERAGE DETERMINATIONS.—In the case of a group health plan or health insurance issuer that requires medical information from nonparticipating providers in order to make a coverage determination, the deadline specified under subparagraph (A) shall begin when the plan or issuer receives such information. Nonparticipating providers shall make reasonable and diligent efforts to expeditiously gather and forward all necessary information to the plan or issuer in order to receive timely payment.

(c) EXPEDITED TREATMENT.—

(1) REQUEST FOR EXPEDITED TREATMENT.—A covered individual (or an authorized representative of the individual) may request that the plan or issuer expedite a coverage determination involving the issues described in subparagraphs (C), (D), or (E) of section 101(a)(2).

(2) WHO MAY REQUEST.—To request expedited treatment of a coverage determination, a covered individual (or authorized representative of the individual) shall submit an oral or written request directly

to the plan or issuer (or, if applicable, to the entity that the plan or issuer has designated as responsible for making the determination).

(3) PROVIDER SUPPORT.—

(A) IN GENERAL.—A physician or other health care provider may provide oral or written support for a request for expedited treatment under this subsection.

(B) PROHIBITION OF PUNITIVE ACTION.—A group health plan and a health insurance issuer in connection with the provision of health insurance coverage shall not take or threaten to take any punitive action against a physician or other health care provider acting on behalf or in support of a covered individual seeking expedited treatment under this subsection.

(4) PROCESSING OF REQUESTS.—A group health plan and a health insurance issuer in connection with the provision of health insurance coverage shall establish and maintain the following procedures for processing requests for expedited treatment of coverage determinations:

(A) An efficient and convenient means for the submission of oral and written requests for expedited treatment. The plan or issuer shall

document all oral requests in writing and maintain the documentation in the case file of the covered individual involved.

(B) A means for deciding promptly whether to expedite a determination, based on the following requirements:

(i) For a request made or supported by a physician, the plan or issuer shall expedite the coverage determination if the physician indicates that applying the standard deadline under subsection (b)(2) for making the determination could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(ii) For another request, the plan or issuer shall expedite the coverage determination if the plan or issuer determines that applying such standard deadline for making the determination could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(5) ACTIONS FOLLOWING DENIAL OF REQUEST FOR EXPEDITED TREATMENT.—If a group health plan or a health insurance issuer in connection with the provision of health insurance coverage denies a request for expedited treatment of a coverage determination under this subsection, the plan or issuer shall—

(A) make the coverage determination within the standard deadline otherwise applicable; and

(B) provide the individual submitting the request with—

(i) prompt oral notice of the denial of the request, and

(ii) within 2 business days a written notice that—

(I) explains that the plan or issuer will process the coverage determination request within the standard deadlines;

(II) informs the requester of the right to file a grievance if the requester disagrees with the plan's or issuer's decision not to expedite the determination; and

(III) provides instructions about the grievance process and its timeframes.

(6) ACTION ON ACCEPTED REQUEST FOR EXPEDITED TREATMENT.—If a group health plan or health insurance issuer grants a request for expedited treatment of a coverage determination, the plan or issuer shall make the determination and provide the notice under subsection (d) within the deadlines specified under subsection (b)(3).

(d) NOTICE OF COVERAGE DETERMINATIONS.—

(1) REQUIREMENT.—

(A) IN GENERAL.—A group health plan or health insurance issuer that makes a coverage determination that—

(i) is completely favorable to the covered individual shall provide the party submitting the request for the coverage determination with notice of such determination; or

(ii) is adverse, in whole or in part, to the covered individual shall provide such party with written notice of the determination, including the information described in subparagraph (B).

(B) CONTENT OF WRITTEN NOTICE.—A written notice under subparagraph (A)(ii) shall—

(i) provide the specific reasons for the determination (including, in the case of a determination relating to utilization review, the clinical rationale for the determination) in clear and understandable language;

(ii) include notice of the availability of the clinical review criteria relied upon in making the coverage determination;

(iii) describe the reconsideration and review processes established to carry out sections 105 and 106, including the right to, and conditions for, obtaining expedited consideration of requests for reconsideration or review; and

(iv) comply with any other requirements specified by the appropriate Secretary.

(2) FAILURE TO PROVIDE TIMELY NOTICE.—Any failure of a group health plan or health insurance issuer to provide a covered individual with timely notice of a coverage determination as specified in this section shall constitute an adverse cov-

erage determination and a timely request for a reconsideration with respect to such determination shall be deemed to have been made pursuant to the section 105(a)(2).

(3) PROVISION OF ORAL NOTICE WITH WRITTEN CONFIRMATION IN CASE OF EXPEDITED TREATMENT.—If a group health plan or health insurance issuer grants a request for expedited treatment under subsection (c), the plan or issuer may first provide notice of the coverage determination orally within the deadlines established under subsection (b)(3) and then shall mail written confirmation of the determination within 2 business days of the date of oral notification.

SEC. 105. INTERNAL APPEALS (RECONSIDERATIONS).

(a) REQUIREMENT.—

(1) RESPONSIBILITIES.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain procedures for making timely reconsiderations of coverage determinations in accordance with this section. Under this section, the plan or issuer shall have a standard procedure for making such determinations, and procedures for expediting such determinations in cases in which application of

the standard deadlines could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(2) PARTIES WHO MAY REQUEST RECONSIDERATION.—Any party to a coverage determination may request a reconsideration of the determination under this section. Such party shall submit an oral or written request directly with the group health plan or health insurance issuer that made the determination. The party who files a request for reconsideration may withdraw it by filing a written request for withdrawal with the group health plan or health insurance issuer involved.

(3) DEADLINE FOR FILING REQUEST.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a party to a coverage determination shall submit the request for a reconsideration within 60 calendar days from the date of the written notice of the coverage determination.

(B) EXTENDING TIME FOR FILING REQUEST.—Such a party may submit a written request to the plan or issuer to extend the deadline specified in subparagraph (A). If such a

party demonstrates in the request for the extension good cause for such extension, the plan or issuer may extend the deadline.

(4) PARTIES TO THE RECONSIDERATION.—

(A) IN GENERAL.—The parties to the reconsideration are the parties to the coverage determination, as described in section 104(a)(2), and any other provider or entity (other than the plan or issuer) whose rights with respect to the coverage determination may be affected by the reconsideration (as determined by the entity that conducts the reconsideration).

(B) OPPORTUNITY TO SUBMIT EVIDENCE.—A group health plan and a health insurance issuer shall provide the parties to the reconsideration with a reasonable opportunity to present evidence and allegations of fact or law, related to the issue in dispute, in person as well as in writing. The plan or issuer shall inform the parties of the conditions for submitting the evidence, especially any time limitations.

(5) EFFECT OF RECONSIDERATION.—A decision of a plan or issuer after reconsideration is binding

on all parties unless it is reviewed pursuant to section 106.

(6) LIMITATION ON CONDUCTING RECONSIDERATION.—In conducting the reconsideration under this subsection, the following rules shall apply:

(A) The person or persons conducting the reconsideration shall not have been involved in making the underlying coverage determination that is the basis for such reconsideration.

(B) If the issuer involved in the reconsideration is the plan's or issuer's denial of coverage based on a lack of medical necessity, a clinical peer (as defined in section 2(c)(2)) shall make the reconsidered determination.

(7) RECONSIDERATION DEFINED.—In this subtitle, the term ''reconsideration'' means a review under this section of a coverage determination that is adverse to the covered individual involved, including a review of the evidence and findings upon which it was based and any other evidence the parties submit or the group health plan or health insurance issuer obtains.

(b) DETERMINATION BY DEADLINE.—

(1) IN GENERAL.—In the case of a request for a reconsideration, the group health plan or health

insurance issuer shall provide notice pursuant to subsection (d) to the person submitting the request of its determination as expeditiously as the health condition of the covered individual involved requires, but in no case later than the deadline established under paragraph (2) or, if a request for expedited treatment of a reconsideration is granted under subsection (c), the deadline established under paragraph (3).

(2) STANDARD DEADLINE.—

(A) IN GENERAL.—The deadline established under this paragraph is, subject to subparagraph (B)—

(i) in the case of a reconsideration regarding the coverage of benefits, 30 calendar days after the date the plan or issuer receives the request for the reconsideration, or

(ii) in other cases, 60 days after such date.

(B) EXTENSION.—The plan or issuer may extend the deadline under subparagraph (A) by up to 14 calendar days if—

(i) the covered individual (or an authorized representative of the individual) requests the extension; or

(ii) the plan or issuer justifies to the applicable authority a need for additional information to make the reconsideration and how the delay is in the interest of the covered individual.

(3) EXPEDITED TREATMENT DEADLINE.—

(A) IN GENERAL.—The deadline established under this paragraph is, subject to subparagraphs (B) and (C), 72 hours after the date the plan or issuer receives the request for the expedited treatment under subsection (d).

(B) EXTENSION.—The plan or issuer may extend the deadline under subparagraph (A) by up to 5 calendar days if—

(i) the covered individual (or an authorized representative of the individual) requests the extension; or

(ii) the plan or issuer justifies to the applicable authority a need for additional information to make the reconsideration and how the delay is in the interest of the covered individual.

(C) HOW INFORMATION FROM NONPARTICIPATING PROVIDERS AFFECTS DEADLINES FOR EXPEDITED RECONSIDERATIONS.—In the case of a group health plan or health insurance issuer that requires medical information from nonparticipating providers in order to make a reconsideration, the deadline specified under subparagraph (A) shall begin when the plan or issuer receives such information. Nonparticipating providers shall make reasonable and diligent efforts to expeditiously gather and forward all necessary information to the plan or issuer in order to receive timely payment.

(c) EXPEDITED TREATMENT.—

(1) REQUEST FOR EXPEDITED TREATMENT.—A covered individual (or an authorized representative of the individual) may request that the plan or issuer expedite a reconsideration involving the issues described in subparagraphs (C), (D), or (E) of section 101(a)(2).

(2) WHO MAY REQUEST.—To request expedited treatment of a reconsideration, a covered individual (or an authorized representative of the individual) shall submit an oral or written request directly to the plan or issuer (or, if applicable, to the entity

that the plan or issuer has designated as responsible for making the decision relating to the reconsideration).

(3) PROVIDER SUPPORT.—

(A) IN GENERAL.—A physician or other health care provider may provide oral or written support for a request for expedited treatment under this subsection.

(B) PROHIBITION OF PUNITIVE ACTION.—A group health plan and a health insurance issuer in connection with the provision of health insurance coverage shall not take or threaten to take any punitive action against a physician or other health care provider acting on behalf or in support of a covered individual seeking expedited treatment under this subsection.

(4) PROCESSING OF REQUESTS.—A group health plan and a health insurance issuer in connection with the provision of health insurance coverage shall establish and maintain the following procedures for processing requests for expedited treatment of reconsiderations:

(A) An efficient and convenient means for the submission of oral and written requests for expedited treatment. The plan or issuer shall

document all oral requests in writing and maintain the documentation in the case file of the covered individual involved.

(B) A means for deciding promptly whether to expedite a reconsideration, based on the following requirements:

(i) For a request made or supported by a physician, the plan or issuer shall expedite the reconsideration if the physician indicates that applying the standard deadline under subsection (b)(2) for making the reconsideration determination could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(ii) For another request, the plan or issuer shall expedite the reconsideration if the plan or issuer determines that applying such standard deadline for making the reconsideration determination could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(5) ACTIONS FOLLOWING DENIAL OF REQUEST FOR EXPEDITED TREATMENT.—If a group health plan or a health insurance issuer in connection with the provision of health insurance coverage denies a request for expedited treatment of a reconsideration under this subsection, the plan or issuer shall—

(A) make the reconsideration determination within the standard deadline otherwise applicable; and

(B) provide the individual submitting the request with—

(i) prompt oral notice of the denial of the request, and

(ii) within 2 business days a written notice that—

(I) explains that the plan or issuer will process the reconsideration request within the standard deadlines;

(II) informs the requester of the right to file a grievance if the requester disagrees with the plan's or issuer's decision not to expedite the reconsideration; and

(III) provides instructions about the grievance process and its timeframes.

(6) ACTION ON ACCEPTED REQUEST FOR EXPEDITED TREATMENT.—If a group health plan or health insurance issuer grants a request for expedited treatment of a reconsideration, the plan or issuer shall make the reconsideration determination and provide the notice under subsection (d) within the deadlines specified under subsection (b)(3).

(d) NOTICE OF DECISION IN RECONSIDERATIONS.—

(1) REQUIREMENT.—

(A) IN GENERAL.—A group health plan or health insurance issuer that makes a decision in the reconsideration that—

(i) is completely favorable to the covered individual shall provide the party submitting the request for the reconsideration with notice of such decision; or

(ii) is adverse, in whole or in part, to the covered individual shall—

(I) provide such party with written notice of the decision, including the information described in subparagraph (B), and

(II) prepare the case file (including such notice) for the covered individual involved, to be available for submission (if requested) under section 106(a).

(B) CONTENT OF WRITTEN NOTICE.—The written notice under subparagraph (A)(ii)(I) shall—

(i) provide the specific reasons for the decision in the reconsideration (including, in the case of a decision relating to utilization review, the clinical rationale for the decision) in clear and understandable language;

(ii) include notice of the availability of the clinical review criteria relied upon in making the decision;

(iii) describe the review processes established to carry out sections 106, including the right to, and conditions for, obtaining expedited consideration of requests for review under such section; and

(iv) comply with any other requirements specified by the appropriate Secretary.

(2) FAILURE TO PROVIDE TIMELY NOTICE.—Any failure of a group health plan or health insurance issuer to provide a covered individual with timely notice of a decision in a reconsideration as specified in this section shall constitute an affirmation of the adverse coverage determination and the plan or issuer shall submit the case file to the qualified external appeal entity under section 106 within 24 hours of expiration of the deadline otherwise applicable.

(3) PROVISION OF ORAL NOTICE WITH WRITTEN CONFIRMATION IN CASE OF EXPEDITED TREATMENT.—If a group health plan or health insurance issuer grants a request for expedited treatment under subsection (c), the plan or issuer may first provide notice of the decision in the reconsideration orally within the deadlines established under subsection (b)(3) and then shall mail written confirmation of the decision within 2 business days of the date of oral notification.

(4) AFFIRMATION OF AN ADVERSE COVERAGE DETERMINATION UNDER EXPEDITED TREATMENT.—If, as a result of its reconsideration, the plan or issuer affirms, in whole or in part, a coverage determination that is adverse to the covered individual

and the reconsideration received expedited treatment under subsection (c), the plan or issuer shall submit the case file (including the written notice of the decision in the reconsideration) to the qualified external appeal entity as expeditiously as the covered individual's health condition requires, but in no case later than within 24 hours of its affirmation. The plan or issuer shall make reasonable and diligent efforts to assist in gathering and forwarding information to the qualified external appeal entity.

(5) NOTIFICATION OF INDIVIDUAL.—If the plan or issuer refers the matter to an qualified external appeal entity under paragraph (2) or (4), it shall concurrently notify the individual (or an authorized representative of the individual) of that action.

SEC. 106. EXTERNAL APPEALS (REVIEWS).

(a) REVIEW BY QUALIFIED EXTERNAL APPEAL ENTITY.—

(1) IN GENERAL.—If a qualified external appeal entity obtains a case file under section 105(d) or under paragraph (2) and determines that—

(A) the individual's appeal is supported by the opinion of the individual's treating physician; or

(B) such appeal is not so supported but—

(i) there is a significant financial amount in controversy (as defined by the Secretary); or

(ii) the appeal involves services for the diagnosis, treatment, or management of an illness, disability, or condition which the entity finds, in accordance with standards established by the entity and approved by the Secretary, constitutes a condition that could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development;

the entity shall review and resolve under this section any remaining issues in dispute.

(2) REQUEST FOR REVIEW.—

(A) IN GENERAL.—A party to a reconsidered determination under section 105 that receives notice of an unfavorable determination under section 105(d) may request a review of such determination by a qualified external appeal entity under this section.

(B) TIME FOR REQUEST.—To request such a review, such party shall submit an oral or

written request directly to the plan or issuer (or, if applicable, to the entity that the plan or issuer has designated as responsible for making the determination).

(C) IF REVIEW IS REQUESTED.—If a party provides the plan or issuer (or such an entity) with notice of a request for such review, the plan or issuer (or such entity) shall submit the case file to the qualified external appeal entity as expeditiously as the covered individual's health condition requires, but in no case later than 2 business days from the date the plan or issuer (or entity) receives such request. The plan or issuer (or entity) shall make reasonable and diligent efforts to assist in gathering and forwarding information to the qualified external appeal entity.

(3) NOTICE AND TIMING FOR REVIEW.—The qualified external appeal entity shall establish and apply rules for the timing and content of notices for reviews under this section (including appropriate expedited treatment of reviews under this section) that are similar to the applicable requirements for timing and content of notices in the case of reconsiderations under subsections (b), (c), and (d) of section 105.

(4) PARTIES.—The parties to the review by a qualified external appeal entity under this section shall be the same parties listed in section 105(a)(4) who qualified during the plan's or issuer's reconsideration, with the addition of the plan or issuer.

(b) GENERAL ELEMENTS OF EXTERNAL APPEALS.—

(1) CONTRACT WITH QUALIFIED EXTERNAL APPEAL ENTITY.—

(A) CONTRACT REQUIREMENT.—Subject to subparagraph (B), the external appeal review under this section of a determination of a plan or issuer shall be conducted under a contract between the plan or issuer and 1 or more qualified external appeal entities.

(B) ELIGIBILITY FOR DESIGNATION AS EXTERNAL REVIEW ENTITY.—Entities eligible to conduct reviews brought under this subsection shall include—

(i) any State licensed or credentialed external review entity;

(ii) a State agency established for the purpose of conducting independent external reviews; and

(iii) an independent, external entity that contracts with the appropriate Secretary.

(C) LICENSING AND CREDENTIALING.—

(i) IN GENERAL.—In licensing or credentialing entities described in subparagraph (B)(i), the State agent shall use licensing and certification procedures developed by the State in consultation with the National Association of Insurance Commissioners.

(ii) SPECIAL RULE.—In the case of a State that—

(I) has not established such licensing or credentialing procedures within 24 months of the date of enactment of this Act, the State shall license or credential such entities in accordance with procedures developed by the Secretary; or

(II) refuses to designate such entities, the Secretary shall license or credential such entities.

(D) QUALIFICATIONS.—An entity (which may be a governmental entity) shall meet the

following requirements in order to be a qualified external appeal entity:

(i) There is no real or apparent conflict of interest that would impede the entity from conducting external appeal activities independent of the plan or issuer.

(ii) The entity conducts external appeal activities through clinical peers (as defined in section 2(c)(2)).

(iii) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (a)(3).

(iv) The entity meets such other requirements as the appropriate Secretary may impose.

(E) LIMITATION ON PLAN OR ISSUER SELECTION.—If an applicable authority permits more than 1 entity to qualify as a qualified external appeal entity with respect to a group health plan or health insurance issuer and the plan or issuer may select among such qualified entities, the applicable authority—

(i) shall assure that the selection process will not create any incentives for qualified external appeal entities to make a decision in a biased manner; and

(ii) shall implement procedures for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

(F) OTHER TERMS AND CONDITIONS.—The terms and conditions of a contract under this paragraph shall be consistent with the standards the appropriate Secretary shall establish to assure that there is no real or apparent conflict of interest in the conduct of external appeal activities. Such contract shall provide that the direct costs of the process (not including costs of representation of a covered individual or other party) shall be paid by the plan or issuer, and not by the covered individual.

(2) ELEMENTS OF PROCESS.—An external appeal process under this section shall be conducted consistent with standards established by the appropriate Secretary that include at least the following:

(A) FAIR PROCESS; DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination.

(B) OPPORTUNITY TO SUBMIT EVIDENCE, HAVE REPRESENTATION, AND MAKE ORAL PRESENTATION.—Any party to a review under this section—

(i) may submit and review evidence related to the issues in dispute,

(ii) may use the assistance or representation of 1 or more individuals (any of whom may be an attorney), and

(iii) may make an oral presentation.

(C) PROVISION OF INFORMATION.—The plan or issuer involved shall provide timely access to all its records relating to the matter being reviewed under this section and to all provisions of the plan or health insurance coverage (including any coverage manual) relating to the matter.

(3) ADMISSIBLE EVIDENCE.—In addition to personal health and medical information supplied with respect to an individual whose claim for benefits has been appealed and the opinion of the individual's treating physician or health care profes-

sional, an external appeals entity shall take into consideration the following evidence:

(A) The results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

(B) The results of professional consensus conferences conducted or financed in whole or in part by one or more government agencies.

(C) Practice and treatment guidelines prepared or financed in whole or in part by government agencies.

(D) Government-issued coverage and treatment policies.

(E) To the extent that the entity determines it to be free of any conflict of interest—

(i) the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal, and

(ii) the results of peer reviews conducted by the plan or issuer involved.

(c) NOTICE OF DETERMINATION BY EXTERNAL APPEAL ENTITY.—

(1) RESPONSIBILITY FOR THE NOTICE.—After the qualified external appeal entity has reviewed and resolved the determination that has been appealed, such entity shall mail a notice of its final decision to the parties.

(2) CONTENT OF THE NOTICE.—The notice described in paragraph (1) shall—

(A) describe the specific reasons for the entity's decisions; and

(B) comply with any other requirements specified by the appropriate Secretary.

(d) EFFECT OF DETERMINATION.—A final decision by the qualified external appeal entity after a review of the determination that has been appealed is final and binding on the group health plan or the health insurance issuer.

Subtitle B—Consumer Information

SEC. 111. HEALTH PLAN INFORMATION.

(a) DISCLOSURE REQUIREMENT.—

(1) GROUP HEALTH PLANS.—A group health plan shall—

(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or

beneficiaries as of such date), at least annually thereafter, and at the beginning of any open enrollment period provided under the plan, the information described in subsection (b) in printed form;

(B) provide to participants and beneficiaries information in printed form on material changes in the information described in paragraphs (1), (2)(A), (2)(B), (3)(A), (6), and (7) of subsection (b), or a change in the health insurance issuer through which coverage is provided, within a reasonable period of (as specified by the Secretary, but not later than 30 days after) the effective date of the changes; and

(C) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in subsections (b) and (c) in printed form.

(2) HEALTH INSURANCE ISSUERS.—A health insurance issuer in connection with the provision of health insurance coverage shall—

(A) provide to individuals enrolled under such coverage at the time of enrollment, and at

least annually thereafter, (and to plan administrators of group health plans in connection with which such coverage is offered) the information described in subsection (b) in printed form;

(B) provide to enrollees and such plan administrators information in printed form on material changes in the information described in paragraphs (1), (2)(A), (2)(B), (3)(A), (6), and (7) of subsection (b), or a change in the health insurance issuer through which coverage is provided, within a reasonable period of (as specified by the Secretary, but later than 30 days after) the effective date of the changes; and

(C) upon request, make available to the applicable authority, to individuals who are prospective enrollees, to plan administrators of group health plans that may obtain such coverage, and to the public the information described in subsections (b) and (c) in printed form.

(3) EXEMPTION AUTHORITY.—Upon application of one or more group health plans or health insurance issuers, the appropriate Secretary, under procedures established by such Secretary, may grant an

exemption to one or more plans or issuers from compliance with one or more of the requirements of paragraph (1) or (2). Such an exemption may be granted for plans and issuers as a class with similar characteristics, such as private fee-for-service plans described in section 1859(b)(2) of the Social Security Act.

(4) ESTABLISHMENT OF INTERNET SITE.—The appropriate Secretaries shall provide for the establishment of 1 or more sites on the Internet to provide technical support and information concerning the rights of participants, beneficiaries, and enrollees under this title.

(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer includes the following:

(1) SERVICE AREA.—The service area of the plan or issuer.

(2) BENEFITS.—Benefits offered under the plan or coverage, including—

(A) covered benefits, including benefits for preventive services, benefit limits, and coverage exclusions, any optional supplemental benefits under the plan or coverage and the terms and

conditions (including premiums or cost-sharing) for such supplemental benefits, and any out-of-area coverage;

(B) cost sharing, such as premiums, deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

(C) the extent to which benefits may be obtained from nonparticipating providers, and any supplemental premium or cost-sharing in so obtaining such benefits;

(D) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of providers participating in the plan or issuer network;

(E) process for determining experimental coverage or coverage in cases of investigational treatments and clinical trials; and

(F) use of a prescription drug formulary.

(3) ACCESS.—A description of the following:

(A) The number, mix, and distribution of health care providers under the plan or coverage.

(B) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

(C) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

(D) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 122(a)(2)(B).

(E) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan or coverage, including the provision of information described in this subsection and subsection (c) to such individuals, including the provision of information in a language other than English if 5 percent of the number of participants, beneficiaries, and enrollees communicate in that language instead

of English, and including the availability of interpreters, audio tapes, and information in braille to meet the needs of people with special communications needs.

(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan or issuer.

(5) EMERGENCY COVERAGE.—Coverage of emergency services, including—

(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(B) the process and procedures of the plan or issuer for obtaining emergency services; and

(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(6) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

(7) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under

the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, the name, address, and telephone number of the applicable authority with respect to the plan or issuer, and the availability of assistance through an ombudsman to individuals in relation to group health plans and health insurance coverage.

(8) QUALITY ASSURANCE.—A summary description of the data on quality indicators and measures submitted under section 112(a) for the plan or issuer, including a summary description of the data on process and outcome satisfaction of participants, beneficiaries, and enrollees (including data on individual voluntary disenrollment and grievances and appeals) described in section 112(b)(3)(D), and notice that information comparing such indicators and measures for different plans and issuers is available through the Agency for Health Care Policy and Research.

(9) SUMMARY OF PROVIDER FINANCIAL INCENTIVES.—A summary description of the information on the types of financial payment incentives (described in section 1852(j)(4) of the Social Security

Act) provided by the plan or issuer under the coverage.

(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

(11) INFORMATION ON LICENSURE.—Information on the licensure, certification, or accreditation status of the plan or issuer.

(12) AVAILABILITY OF TECHNICAL SUPPORT AND INFORMATION.—Notice that technical support and information concerning the rights of participants, beneficiaries, and enrollees under this title are available from the Secretary of Labor (in the case of group health plans) or the Secretary of Health and Human Services (in the case of health insurance issuers), including the telephone numbers and mailing address of the regional offices of the appropriate Secretary and the Internet address to obtain such information and support.

(13) ADVANCE DIRECTIVES AND ORGAN DONATION DECISIONS.—Information regarding the use of advance directives and organ donation decisions under the plan or coverage.

(14) PARTICIPATING PROVIDER LIST.—A list of current participating health care providers for the relevant geographic area, including the name, address and telephone number of each provider.

(15) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request and how and where (such as the telephone number and Internet website) such information may be obtained.

(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 102(a), including under any drug formulary program under section 123(b).

(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and internal and external appeals and on the disposition in the aggregate of such matters, including information on the reasons for the disposition of external appeal cases.

(3) METHOD OF COMPENSATION.—A summary description as to the method of compensation of participating health care professionals and health care facilities, including information on the types of financial payment incentives (described in section 1852(j)(4) of the Social Security Act) provided by the plan or issuer under the coverage and on the proportion of participating health care professionals who are compensated under each type of incentive under the plan or coverage.

(4) CONFIDENTIALITY POLICIES AND PROCEDURES.—A description of the policies and procedures established to carry out section 112.

(5) FORMULARY RESTRICTIONS.—A description of the nature of any drug formula restrictions, including the specific prescription medications included in any formulary and any provisions for obtaining off-formulary medications.

(6) ADDITIONAL INFORMATION ON PARTICIPATING PROVIDERS.—For each current participating health care provider described in subsection (b)(14)—

(A) the licensure or accreditation status of the provider;

(B) to the extent possible, an indication of whether the provider is available to accept new patients;

(C) in the case of medical personnel, the education, training, speciality qualifications or certification, speciality focus, affiliation arrangements, and specialty board certification (if any) of the provider; and

(D) any measures of consumer satisfaction and quality indicators for the provider.

(7) PERCENTAGE OF PREMIUMS USED FOR BENEFITS (LOSS-RATIOS).—In the case of health insurance coverage only (and not with respect to group health plans that do not provide coverage through health insurance coverage), a description of the overall loss-ratio for the coverage (as defined in accordance with rules established or recognized by the Secretary of Health and Human Services).

(8) QUALITY INFORMATION DEVELOPED.—Quality information on processes and outcomes developed as part of an accreditation or licensure process for the plan or issuer to the extent the information is publicly available.

(d) FORM OF DISCLOSURE.—

(1) UNIFORMITY.—Information required to be disclosed under this section shall be provided in accordance with uniform, national reporting standards specified by the Secretary, after consultation with applicable State authorities, so that prospective enrollees may compare the attributes of different issuers and coverage offered within an area within a type of coverage. Such information shall be provided in an accessible format that is understandable to the average participant, beneficiary, or enrollee involved.

(2) INFORMATION INTO HANDBOOK.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from making the information under subsections (b) and (c) available to participants, beneficiaries, and enrollees through an enrollee handbook or similar publication.

(3) UPDATING PARTICIPATING PROVIDER INFORMATION.—The information on participating health care providers described in subsections (b)(14) and (c)(6) shall be updated within such reasonable period as determined appropriate by the Secretary. A group health plan or health insurance issuer shall be considered to have complied with the provisions of such subsection if the plan or issuer

provides the directory or listing of participating providers to participants and beneficiaries or enrollees once a year and such directory or listing is updated within such a reasonable period to reflect any material changes in participating providers. Nothing in this section shall prevent a plan or issuer from changing or updating other information made available under this section.

(4) RULE OF MAILING TO LAST ADDRESS.—For purposes of this section, a plan or issuer, in reliance on records maintained by the plan or issuer, shall be deemed to have met the requirements of this section with respect to the disclosure of information to a participant, beneficiary, or enrollee if the plan or issuer transmits the information requested to the participant, beneficiary, or enrollee at the address contained in such records with respect to such participant, beneficiary, or enrollee.

(e) ENROLLEE ASSISTANCE.—

(1) IN GENERAL.—Each State that obtains a grant under paragraph (3) shall provide for creation and operation of a Health Insurance Ombudsman through a contract with a not-for-profit organization that operates independent of group health plans and

health insurance issuers. Such Ombudsman shall be responsible for at least the following:

(A) To provide consumers in the State with information about health insurance coverage options or coverage options offered within group health plan.

(B) To provide counseling and assistance to enrollees dissatisfied with their treatment by health insurance issuers and group health plans in regard to such coverage or plans and with respect to grievances and appeals regarding determinations under such coverage or plans.

(2) FEDERAL ROLE.—In the case of any State that does not provide for such an Ombudsman under paragraph (1), the Secretary may provide for the creation and operation of a Health Insurance Ombudsman through a contract with a not-for-profit organization that operates independent of group health plans and health insurance issuers and that is to provide consumers in the State with information about health insurance coverage options or coverage options offered within group health plans.

(3) ELIGIBILITY.—To be eligible to serve as a Health Insurance Ombudsman under this section, a

not-for-profit organization shall provide assurances that—

(A) the organization has no real or perceived conflict of interest in providing advice and assistance to consumers regarding health insurance coverage, and

(B) the organization is independent of health insurance issuers, health care providers, health care payors, and regulators of health care or health insurance.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Health and Human Services such amounts as may be necessary to provide for grants to States for contracts for Health Insurance Ombudsmen under paragraph (1) or contracts for such Ombudsmen under paragraph (2).

(5) CONSTRUCTION.—Nothing in this section shall be construed to prevent the use of other forms of enrollee assistance.

(f) CONSTRUCTION.—Nothing in this section shall be construed as requiring public disclosure of individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider.

SEC. 112. HEALTH CARE QUALITY INFORMATION.

(a) COLLECTION AND SUBMISSION OF INFORMATION ON QUALITY INDICATORS AND MEASURES.—

(1) IN GENERAL.—A group health plan and a health insurance issuer that offers health insurance coverage shall collect and submit to the Director for the Agency for Health Care Policy and Research (in this section referred to as the ''Director'') aggregate data on quality indicators and measures (as defined in subsection (g)) that includes the minimum uniform data set specified under subsection (b). Such data shall not include patient identifiers.

(2) DATA SAMPLING METHODS.—The Director shall develop data sampling methods for the collection of data under this subsection.

(3) EXEMPTION AUTHORITY.—The provisions of section 111(a)(3) shall apply to the requirements of paragraph (1) in the same manner as they apply to the requirements referred to in such section.

(b) MINIMUM UNIFORM DATA SET.—

(1) IN GENERAL.—The Secretary shall specify (and may from time to time update) by rule the data required to be included in the minimum uniform data set under subsection (a) and the standard format for such data.

(2) DESIGN.—Such specification shall—

(A) take into consideration the different populations served (such as children and individuals with disabilities);

(B) be consistent where appropriate with requirements applicable to Medicare+Choice health plans under 1851(d)(4)(D) of the Social Security Act;

(C) take into consideration such differences in the delivery system among group health plans and health insurance issuers as the Secretary deems appropriate;

(D) be consistent with standards adopted to carry out part C of title XI of the Social Security Act; and

(E) be consistent where feasible with existing health plan quality indicators and measures used by employers and purchasers.

(3) MINIMUM DATA.—The data in such set shall include, to the extent determined feasible by the appropriate Secretary, at least—

(A) data on process measures of clinical performance for health care services provided by health care professionals and facilities;

(B) data on outcomes measures of morbidity and mortality including to the extent fea-

sible and appropriate data for pediatric and gender-specific measures; and

(C) data on data on satisfaction of such individuals, including data on voluntary disenrollment and grievances.

The minimum data set under this paragraph shall be established by the appropriate Secretaries using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(c) DISSEMINATION OF INFORMATION.—

(1) IN GENERAL.—The Director shall publicly disseminate (through printed media and the Internet) information on the aggregate data submitted under this section.

(2) FORMATS.—The information shall be disseminated in a manner that provides for a comparison of health care quality among different group health plans and health insurance issuers, with appropriate differentiation by delivery system. In disseminating the information, the Director may reference an appropriate benchmark (or benchmarks) for performance with respect to specific quality indicators and measures (or groups of such measures).

(d) HEALTH CARE QUALITY RESEARCH AND INFORMATION.—The Secretary of Health and Human Services,

acting through the Director, shall conduct and support research demonstration projects, evaluations, and the dissemination of information with respect to measurement, status, improvement, and presentation of quality indicators and measures and other health care quality information.

(e) NATIONAL REPORTS ON HEALTH CARE QUALITY.—

(1) REPORT ON NATIONAL GOALS.—Not later than 18 months after the date of enactment of this Act, and every 2 years thereafter, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress and the President a report that—

(A) establishes national goals for the improvement of the quality of health care; and

(B) contains recommendations for achieving the national goals established under paragraph (1).

(2) REPORT ON HEALTH RELATED TOPICS.—Not later than 30 months after the date of enactment of this Act and every 2 years thereafter, such Secretary shall prepare and submit to Congress and the President a report that addresses at least 1 of the following (or a related matter):

(A) The availability, applicability, and appropriateness of information to consumers regarding the quality of their health care.

(B) The state of information systems and data collecting capabilities for measuring and reporting on quality indicators.

(C) The impact of quality measurement on access to and the cost of medical care.

(D) Barriers to continuous quality improvement in medical care.

(E) The state of health care quality measurement research and development.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $25,000,000 for each fiscal year (beginning with fiscal year 1999) to carry out this section. Any such amounts appropriated for a fiscal year shall remain available, without fiscal year limitation, until expended.

(g) QUALITY INDICATORS AND MEASURES DEFINED.—For purposes of this section, the term ''quality indicators and measures'' means structural characteristics, patient-encounter data, and the subsequent health status change of a patient as a result of health care services provided by health care professionals and facilities.

SEC. 113. CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.

A group health plan or a health insurance issuer shall establish procedures with respect to medical records or other health information maintained regarding participants, beneficiaries, and enrollees to safeguard the privacy of any individually identifiable information about them.

SEC. 114. QUALITY ASSURANCE.

(a) REQUIREMENT.—A group health plan, and a health insurance issuer that offers health insurance coverage, shall establish and maintain an ongoing, internal quality assurance and continuous quality improvement program that meets the requirements of subsection (b).

(b) PROGRAM REQUIREMENTS.—The requirements of this subsection for a quality improvement program of a plan or issuer are as follows:

(1) ADMINISTRATION.—The plan or issuer has an identifiable unit with responsibility for administration of the program.

(2) WRITTEN PLAN.—The plan or issuer has a written plan for the program that is updated annually and that specifies at least the following:

(A) The activities to be conducted.

(B) The organizational structure.

(C) The duties of the medical director.

(D) Criteria and procedures for the assessment of quality.

(3) SYSTEMATIC REVIEW.—The program provides for systematic review of the type of health services provided, consistency of services provided with good medical practice, and patient outcomes.

(4) QUALITY CRITERIA.—The program—

(A) uses criteria that are based on performance and patient outcomes where feasible and appropriate;

(B) includes criteria that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate;

(C) includes methods for informing covered individuals of the benefit of preventive care and what specific benefits with respect to preventive care are covered under the plan or coverage; and

(D) makes available to the public a description of the criteria used under subparagraph (A).

(5) SYSTEM FOR IDENTIFYING.—The program has procedures for identifying possible quality concerns by providers and enrollees and for remedial actions to correct quality problems, including written procedures for responding to concerns and taking appropriate corrective action.

(6) DATA ANALYSIS.—The program provides, using data that include the data collected under section 112, for an analysis of the plan's or issuer's performance on quality measures.

(7) DRUG UTILIZATION REVIEW.—The program provides for a drug utilization review program which—

(A) encourages appropriate use of prescription drugs by participants, beneficiaries, and enrollees and providers, and

(B) takes appropriate action to reduce the incidence of improper drug use and adverse drug reactions and interactions.

(c) DEEMING.—For purposes of subsection (a), the requirements of—

(1) subsection (b) (other than paragraph (5)) are deemed to be met with respect to a health insurance issuer that is a qualified health maintenance

organization (as defined in section 1310(c) of the Public Health Service Act); or

(2) subsection (b) are deemed to be met with respect to a health insurance issuer that is accredited by a national accreditation organization that the Secretary certifies as applying, as a condition of certification, standards at least a stringent as those required for a quality improvement program under subsection (b).

(d) VARIATION PERMITTED.—The Secretary may provide for variations in the application of the requirements of this section to group health plans and health insurance issuers based upon differences in the delivery system among such plans and issuers as the Secretary deems appropriate.

(e) CONSULTATION IN MEDICAL POLICIES.—A group health plan, and health insurance issuer that offers health insurance coverage, shall consult with participating physicians (if any) regarding the plan's or issuer's medical policy, quality, and medical management procedures.

Subtitle C—Patient Protection Standards

SEC. 121. EMERGENCY SERVICES.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to emergency services (as defined in paragraph (2)(B)), the plan or issuer shall cover emergency services furnished under the plan or coverage—

(A) without the need for any prior authorization determination;

(B) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating health care provider—

(i) the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider, and

(ii) the plan or issuer pays an amount that is not less than the amount paid to a participating health care provider for the same services; and

(D) without regard to any other term or condition of such plan or coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in subparagraph (A)), and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—In the case of services (other than emergency services) for which benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) if the services are maintenance care or post-stabilization care covered under the guidelines estab-

lished under section 1852(d)(2) of the Social Security Act (relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after an enrollee has been determined to be stable), in accordance with regulations established to carry out such section.

SEC. 122. ENROLLEE CHOICE OF HEALTH PROFESSIONALS AND PROVIDERS.

(a) CHOICE OF PERSONAL HEALTH PROFESSIONAL.—

(1) PRIMARY CARE.—A group health plan, and a health insurance issuer that offers health insurance coverage, shall permit each participant, beneficiary, and enrollee—

(A) to receive primary care from any participating primary care provider who is available to accept such individual, and

(B) in the case of a participant, beneficiary, or enrollee who has a child who is also covered under the plan or coverage, to designate a participating physician who specializes in pediatrics as the child's primary care provider.

(2) SPECIALISTS.—

(A) IN GENERAL.—Subject to subparagraph (B), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care provider who is available to accept such individual for such care.

(B) LIMITATION.—Subparagraph (A) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating providers with respect to such care.

(b) SPECIALIZED SERVICES.—

(1) OBSTETRICAL AND GYNECOLOGICAL CARE.—

(A) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care provider, and an individual who is female has not designated a participating physician

specializing in obstetrics and gynecology as a primary care provider, the plan or issuer—

(i) may not require authorization or a referral by the individual's primary care provider or otherwise for coverage of routine gynecological care (such as preventive women's health examinations) and pregnancy-related services provided by a participating health care professional who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and

(ii) may treat the ordering of other gynecological care by such a participating physician as the authorization of the primary care provider with respect to such care under the plan or coverage.

(B) CONSTRUCTION.—Nothing in subparagraph (A)(ii) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological care so ordered.

(2) SPECIALTY CARE.—

(A) SPECIALTY CARE FOR COVERED SERVICES.—

(i) IN GENERAL.—If—

(I) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer,

(II) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, and

(III) benefits for such treatment are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

(ii) SPECIALIST DEFINED.—For purposes of this paragraph, the term ''specialist'' means, with respect to a condition, a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric exper-

tise) to provide high quality care in treating the condition.

(iii) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under clause (i) be—

(I) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

(II) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this paragraph shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(iv) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under clause (i) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have an appropriate specialist that is available and accessible to treat the individual's condition and that is a participating provider with respect to such treatment.

(v) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to clause (i), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

(B) SPECIALISTS AS PRIMARY CARE PROVIDERS.—

(i) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insur-

ance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in clause (iii)) may receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care. If such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(ii) TREATMENT AS PRIMARY CARE PROVIDER.—Such specialist shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan (referred to in subparagraph (A)(iii)(I)).

(iii) ONGOING SPECIAL CONDITION DEFINED.—In this subparagraph, the term

''special condition'' means a condition or disease that—

(I) is life-threatening, degenerative, or disabling, and

(II) requires specialized medical care over a prolonged period of time.

(iv) TERMS OF REFERRAL.—The provisions of clauses (iii) through (v) of subparagraph (A) apply with respect to referrals under clause (i) of this subparagraph in the same manner as they apply to referrals under subparagraph (A)(i).

(C) STANDING REFERRALS.—

(i) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer

and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist.

(ii) TERMS OF REFERRAL.—The provisions of clauses (iii) through (v) of subparagraph (A) apply with respect to referrals under clause (i) of this subparagraph in the same manner as they apply to referrals under subparagraph (A)(i).

(c) CONTINUITY OF CARE.—

(1) IN GENERAL.—

(A) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, and a health care provider is terminated (as defined in subparagraph (C)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant, beneficiary, or enrollee in the plan or coverage is undergoing a course of treatment from the provider

at the time of such termination, the plan or issuer shall—

(i) notify the individual on a timely basis of such termination, and

(ii) subject to paragraph (3), permit the individual to continue or be covered with respect to the course of treatment with the provider during a transitional period (provided under paragraph (2)) if the plan or issuer is notified orally or in writing of the facts and circumstances concerning the course of treatment.

(B) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of subparagraph (A) (and the succeeding provisions of this section) shall apply under the group health plan in the same manner as if there had been a direct contract between the group health plan and the provider

that had been terminated, but only with respect to benefits that are covered under the group health plan after the contract termination.

(C) TERMINATION.—In this section, the term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

(2) TRANSITIONAL PERIOD.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) through (D), the transitional period under this subsection shall extend for at least 90 days from the date of the notice described in paragraph (1)(A)(i) of the provider's termination.

(B) INSTITUTIONAL CARE.—The transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status.

(C) PREGNANCY.—If—

(i) a participant, beneficiary, or enrollee has entered the second trimester of pregnancy at the time of a provider's termination of participation, and

(ii) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

(D) TERMINAL ILLNESS.—If—

(i) a participant, beneficiary, or enrollee was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

(ii) the provider was treating the terminal illness before the date of termination,

the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness, but in no case is

the transitional period required to extend for longer than 180 days.

(3) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under paragraph (1)(A)(ii) upon the provider agreeing to the following terms and conditions:

(A) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in paragraph (1)(B), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in paragraph (1)(A) had not been terminated.

(B) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under subparagraph (A) and to provide to such plan or issuer

necessary medical information related to the care provided.

(C) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding utilization review and referrals, and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

(d) PROTECTION AGAINST INVOLUNTARY DISENROLLMENT BASED ON CERTAIN CONDITIONS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer in connection with the provision of health insurance coverage may not disenroll an individual under the plan or coverage because the individual's behavior is considered disruptive, unruly, abusive, or uncooperative to the extent that the individual's continued enrollment under the coverage seriously impairs the plan's or issuer's ability to furnish covered services if the circumstances for the individual's behavior is

directly related to diminished mental capacity, severe and persistent mental illness, or a serious childhood mental and emotional disorder.

(2) EXCEPTION.—Paragraph (1) shall not apply if the behavior engaged in directly threatens bodily injury to any person.

(e) GENERAL ACCESS.—

(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage, that provides benefits, in whole or in part, through participating health care providers shall have (in relation to the coverage) a sufficient number, distribution, and variety of qualified participating health care providers to ensure that all covered health care services, including specialty services, will be available and accessible in a timely manner to all participants, beneficiaries, and enrollees under the plan or coverage.

(2) TREATMENT OF CERTAIN PROVIDERS.—The qualified health care providers under paragraph (1) may include Federally qualified health centers, rural health clinics, migrant health centers, high-volume, disproportionate share hospitals, and other essential community providers located in the service area of the plan or issuer and shall include such providers

if necessary to meet the standards established to carry out such subsection.

SEC. 123. ACCESS TO APPROVED SERVICES.

(a) COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.—

(1) COVERAGE.—

(A) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in paragraph (2)), the plan or issuer—

(i) may not deny the individual participation in the clinical trial referred to in paragraph (2)(B);

(ii) subject to paragraph (3), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(iii) may not discriminate against the individual on the basis of the enrollee's participation in such trial.

(B) EXCLUSION OF CERTAIN COSTS.—For purposes of subparagraph (A)(ii), routine pa-

tient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

(C) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in subparagraph (A) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(2) QUALIFIED INDIVIDUAL DEFINED.—For purposes of paragraph (1), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(A)(i) The individual has a life-threatening or serious illness for which no standard treatment is effective.

(ii) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

(iii) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

(B) Either—

(i) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in subparagraph (A); or

(ii) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in subparagraph (A).

(3) PAYMENT.—

(A) IN GENERAL.—Under this subsection a group health plan or health insurance issuer shall provide for payment for routine patient costs described in paragraph (1)(A) but is not required to pay for costs of items and services that are reasonably expected (as determined by

the Secretary) to be paid for by the sponsors of an approved clinical trial.

(B) PAYMENT RATE.—In the case of covered items and services provided by—

(i) a participating provider, the payment rate shall be at the agreed upon rate, or

(ii) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

(4) APPROVED CLINICAL TRIAL DEFINED.—

(A) IN GENERAL.—In this subsection, the term ''approved clinical trial'' means a clinical research study or clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

(i) The National Institutes of Health.

(ii) A cooperative group or center of the National Institutes of Health.

(iii) Either of the following if the conditions described in subparagraph (B) are met:

(I) The Department of Veterans Affairs.

(II) The Department of Defense.

(B) CONDITIONS FOR DEPARTMENTS.—The conditions described in this subparagraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(5) CONSTRUCTION.—Nothing in this subsection shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

(b) ACCESS TO PRESCRIPTION DRUGS.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that offers health insurance coverage, provides benefits with respect to prescrip-

tion drugs but the coverage limits such benefits to drugs included in a formulary, the plan or issuer shall—

(A) ensure participation of participating physicians and pharmacists in the development of the formulary; and

(B) disclose to providers and, disclose upon request under section 111(c)(5) to participants, beneficiaries, and enrollees, the nature of the formulary restrictions; and

(C) consistent with the standards for a utilization review program under section 102(a), provide for exceptions from the formulary limitation when a non-formulary alternative is medically indicated.

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a group health plan (or health insurance issuer in connection with health insurance coverage) to provide any coverage of prescription drugs or as preventing such a plan or issuer from negotiating higher cost-sharing in the case a non-formulary alternative is provided under paragraph (1)(C).

SEC. 124. NONDISCRIMINATION IN DELIVERY OF SERVICES.

(a) APPLICATION TO DELIVERY OF SERVICES.—Subject to subsection (b), a group health plan, and health insurance issuer in relation to health insurance coverage, may not discriminate against a participant, beneficiary, or enrollee in the delivery of health care services consistent with the benefits covered under the plan or coverage or as required by law based on race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed as relating to the eligibility to be covered, or the offering (or guaranteeing the offer) of coverage, under a plan or health insurance coverage, the application of any pre-existing condition exclusion consistent with applicable law, or premiums charged under such plan or coverage. To the extent that health care providers are permitted under State and Federal law to prioritize the admission or treatment of patients based on such patients' individual religious affiliation, group health plans and health insurance issuers may reflect those priorities in referring patients to such providers.

SEC. 125. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) IN GENERAL.—An organization on behalf of a group health plan (as described in subsection (a)(2)) or

a health insurance issuer shall not penalize (financially or otherwise) a health care professional for advocating on behalf of his or her patient or for providing information or referral for medical care (as defined in section 2791(a)(2) of the Public Health Service Act) consistent with the health care needs of the patient and with the code of ethical conduct, professional responsibility, conscience, medical knowledge, and license of the health care professional.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed as requiring a health insurance issuer or a group health plan to pay for medical care not otherwise paid for or covered by the plan provided by nonparticipating health care professionals, except in those instances and to the extent that the issuer or plan would normally pay for such medical care.

(c) ASSISTANCE AND SUPPORT.—A group health plan or a health insurance issuer shall not prohibit or otherwise restrict a health care professional from providing letters of support to, or in any way assisting, enrollees who are appealing a denial, termination, or reduction of service in accordance with the procedures under subtitle A.

SEC. 126. PROVIDER INCENTIVE PLANS.

(a) PROHIBITION OF TRANSFER OF INDEMNIFICATION.—

(1) IN GENERAL.—No contract or agreement between a group health plan or health insurance issuer (or any agent acting on behalf of such a plan or issuer) and a health care provider shall contain any provision purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions, or omissions of the plan, issuer, or agent (as opposed to the provider).

(2) NULLIFICATION.—Any contract or agreement provision described in paragraph (1) shall be null and void.

(b) PROHIBITION OF IMPROPER PHYSICIAN INCENTIVE PLANS.—

(1) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in subparagraph (A) of such section are met with respect to such a plan.

(2) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual en-

rolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

SEC. 127. PROVIDER PARTICIPATION.

(a) IN GENERAL.—A group health plan and a health insurance issuer that offers health insurance coverage shall, if it provides benefits through participating health care professionals, have a written process for the selection of participating health care professionals under the plan or coverage. Such process shall include—

(1) minimum professional requirements;

(2) providing notice of the rules regarding participation;

(3) providing written notice of participation decisions that are adverse to professionals; and

(4) providing a process within the plan or issuer for appealing such adverse decisions, including the presentation of information and views of the professional regarding such decision.

(b) VERIFICATION OF BACKGROUND.—Such process shall include verification of a health care provider's license and a history of suspension or revocation.

(c) RESTRICTION.—Such process shall not use a high-risk patient base or location of a provider in an area with residents with poorer health status as a basis for excluding providers from participation.

(d) GENERAL NONDISCRIMINATION.—

(1) IN GENERAL.—Subject to paragraph (2), such process shall not discriminate with respect to selection of a health care professional to be a participating health care provider, or with respect to the terms and conditions of such participation, based on the professional's race, color, religion, sex, national origin, age, sexual orientation, or disability (consistent with the Americans with Disabilities Act of 1990).

(2) RULES.—The appropriate Secretary may establish such definitions, rules, and exceptions as may be appropriate to carry out paragraph (1), taking into account comparable definitions, rules, and exceptions in effect under employment-based nondiscrimination laws and regulations that relate to each of the particular bases for discrimination described in such paragraph.

SEC. 128. REQUIRED COVERAGE FOR APPROPRIATE HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER; REQUIRED COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.

(a) COVERAGE OF INPATIENT CARE FOR SURGICAL TREATMENT OF BREAST CANCER.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the surgical treatment of breast cancer (including a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer) is provided for a period of time as is determined by the attending physician, in his or her professional judgment consistent with generally accepted principles of professional medical practice, in consultation with the patient, to be medically necessary or appropriate.

(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician in consultation with the patient determine that a shorter period of hospital stay is medically necessary or appropriate.

(b) COVERAGE OF RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.—A group health plan, and a health insurance issuer providing health insurance coverage, that provides medical and surgical benefits with respect to a mastectomy shall ensure that, in a case in which a mastectomy patient elects breast reconstruction, coverage is provided for—

(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) the costs of prostheses and complications of mastectomy including lymphedemas;

in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant or enrollee upon enrollment and annually thereafter.

(c) NO AUTHORIZATION REQUIRED.—

(1) IN GENERAL.—An attending physician shall not be required to obtain authorization from the plan or issuer for prescribing any length of stay in

connection with a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

(2) PRENOTIFICATION.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from requiring prenotification of an inpatient stay referred to in this section if such requirement is consistent with terms and conditions applicable to other inpatient benefits under the plan or health insurance coverage, except that the provision of such inpatient stay benefits shall not be contingent upon such notification.

(d) PROHIBITIONS.—A group health plan and a health insurance issuer offering health insurance coverage may not—

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to individuals to encourage such individuals to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such

provider provided care to an individual participant, beneficiary, or enrollee in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant, beneficiary, or enrollee in a manner inconsistent with this section; and

(5) subject to subsection (e)(2), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(e) RULES OF CONSTRUCTION.—

(1) IN GENERAL.—Nothing in this section shall be construed to require a patient who is a participant, beneficiary, or enrollee—

(A) to undergo a mastectomy or lymph node dissection in a hospital; or

(B) to stay in the hospital for a fixed period of time following a mastectomy or lymph node dissection.

(2) COST SHARING.—Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or

other cost-sharing in relation to benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer under the plan or health insurance coverage, except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(3) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

Subtitle D—Enhanced Enforcement Authority

SEC. 141. INVESTIGATIONS AND REPORTING AUTHORITY, INJUNCTIVE RELIEF AUTHORITY, AND INCREASED CIVIL MONEY PENALTY AUTHORITY FOR SECRETARY OF HEALTH AND HUMAN SERVICES FOR VIOLATIONS OF PATIENT PROTECTION STANDARDS.

(a) INVESTIGATIONS AND REPORTING AUTHORITY.—

(1) IN GENERAL.—For purposes of carrying out sections 2722(b) and 2761(b) of the Public Health Service Act with respect to enforcement of the provisions of sections 2706 and 2752, respectively, of such Act (as added by title II of this Act)—

(A) the Secretary of Health and Human Services shall have the same authorities with respect to compelling health insurance issuers to produce information and to conducting investigations in cases of violations of such provisions as the Secretary of Labor has under section 504 of the Employee Retirement Income Security Act of 1974 with respect to violations of title I of such Act; and

(B) section 504(c) of the Employee Retirement Income Security Act of 1974 shall apply to investigations conducted under paragraph (1) in the same manner as it applies to investigations conducted under title I of such Act.

(2) REPORTING AUTHORITY.—In exercising authority under paragraph (1), the Secretary may require—

(A) States that have indicated an intention to assume authority under section 2722(a)(1) or 2761(a) of the Public Health Service Act to

report to the Secretary on enforcement efforts undertaken to assure compliance with the requirements of sections 2706 and 2752, respectively, of such Act; and

(B) health insurance issuers to submit reports to assure compliance with such requirements.

(b) AUTHORITY FOR INJUNCTIVE RELIEF.—In addition to the authority referred to in subsection (a), the Secretary of Health and Human Services has the same authority with respect to enforcement of the provisions of this title as the Secretary of Labor has under subsection (a)(5) of section 502 of the Employee Retirement Income Security Act of 1974 (as applied without regard to subsection (b) of that section) and the related provisions of part 5 of subtitle B of title I of such Act with respect to enforcement of such title I of such Act.

(c) INCREASE IN CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—In the case of a civil money penalty that may be imposed under section 2722(b)(2) or 2761(b) of the Public Health Service Act with respect to a failure to meet the provisions of sections 2706 and 2752, respectively, of such Act, the maximum amount of penalty otherwise provided under section 2722(b)(2)(C)(i) of such Act may, not-

withstanding the amounts specified in such section, and subject to paragraph (2), be up to the greatest of the following:

(A) FAILURES INVOLVING UNREASONABLE DENIAL OR DELAY IN BENEFITS IMPACTING ON LIFE OR HEALTH.—In the case of a failure that results in an unreasonable denial or delay in benefits that has seriously jeopardized (or has substantial likelihood of seriously jeopardizing) the individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development, the greater of the following:—

(i) PATTERN OR PRACTICE FAILURE.—If the failure reflects a pattern or practice of wrongful conduct, $250,000, plus the amount (if any) determined under paragraph (2).

(ii) OTHER FAILURES.—In the case of a failure that does not reflect a pattern or practice of wrongful conduct, $50,000 for each individual involved, plus the amount (if any) determined under paragraph (2).

(B) OTHER FAILURES.—In the case of a failure not described in subparagraph (A), the greater of the following:

(i) PATTERN AND PRACTICE FAILURES.—In the case of a failure that reflects a pattern or practice of wrongful conduct $50,000, plus the amount (if any) determined under paragraph (2).

(ii) OTHER FAILURES.—In the case of a failure that does not reflect a pattern or practice of wrongful conduct, $10,000 for each individual involved, plus the amount (if any) determined under paragraph (2).

(2) CONTINUING FAILURE WITHOUT CORRECTION.—In the case of a failure which is not corrected within the first week beginning with the date on which the failure is established, the maximum amount of the penalty under paragraph (1) shall be increased by $10,000 for each full succeeding week in which the failure is not so corrected.

(d) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other amounts authorized to be appropriated, there are authorized to be appropriated to the Secretary of Health and Human Services such sums as may be necessary to carry out this section.

SEC. 142. AUTHORITY FOR SECRETARY OF LABOR TO IMPOSE CIVIL PENALTIES FOR VIOLATIONS OF PATIENT PROTECTION STANDARDS.

(a) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) is amended by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively, and by inserting after paragraph (5) the following new paragraph:

''(6)(A) The Secretary may assess a civil penalty against a person acting in the capacity of a fiduciary of a group health plan (as defined in 733(a)) so as to cause a violation of section 713.

''(B) Subject to subparagraph (C), the maximum amount which may be assessed under subparagraph (A) is the greatest of the following:

''(i) In the case of a failure that results in an unreasonable denial or delay in benefits that seriously jeopardized (or has substantial likelihood of seriously jeopardizing) the individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development, the greater of the following:

''(I) If the failure reflects a pattern or practice of wrongful conduct, $250,000, plus the amount (if any) determined under subparagraph (C).

''(II) In the case of a failure that does not reflect a pattern or practice of wrongful conduct, $50,000 for each individual involved, plus the amount (if any) determined under subparagraph (C).

''(ii) In the case of a failure not described in clause (i), the greater of the following:

''(I) In the case of a failure that reflects a pattern or practice of wrongful conduct $50,000, plus the amount (if any) determined under subparagraph (C).

''(II) In the case of a failure that does not reflect a pattern or practice of wrongful conduct, $10,000 for each individual involved, plus the amount (if any) determined under subparagraph (C).

''(C) In the case of a failure which is not corrected within the first week beginning with the date on which the failure is established, the maximum amount of the penalty under subparagraph (B) shall be increased by $10,000 for each full succeeding week in which the failure is not so corrected.''.

(b) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by striking

''paragraph (2), (4), (5), or (6)'' and inserting ''paragraph (2), (4), (5), (6), or (7)''.

(c) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other amounts authorized to be appropriated, there are authorized to be appropriated to the Secretary of Labor such sums as may be necessary to carry out the amendments made by this section.

TITLE II—PATIENT PROTECTION STANDARDS UNDER PUBLIC HEALTH SERVICE ACT

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2706. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I of the Promoting Responsible Managed Care Act of 1998, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2706)'' after ''requirements of such subparts''.

(c) REFERENCE TO ENHANCED ENFORCEMENT AUTHORITY.—For provisions providing for enhanced authority to enforce the patient protection requirements of title I under the Public Health Service Act, see section 141.

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

''SEC. 2752. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title I of the Promoting Responsible Managed Care Act of 1998 with respect to individual health insurance cov-

erage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.''.

TITLE III—PATIENT PROTECTION STANDARDS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 713. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering

group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Promoting Responsible Managed Care Act of 1998 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Promoting Responsible Managed Care Act of 1998 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 121 (relating to access to emergency care).

''(B) Section 122 (relating to choice of providers).

''(C) Section 122(b) (relating to specialized services).

''(D) Section 122(c)(1)(A) (relating to continuity in case of termination of provider contract) and section 122(c)(1)(B) (relating to continuity in case of termination of issuer contract), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(E) Section 123(a) (relating to coverage for individuals participating in approved clinical trials.)

''(F) Section 123(b) (relating to access to needed prescription drugs).

''(G) Section 122(e) (relating to adequacy of provider network).

''(H) Subtitle B (relating to consumer information).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 111 of such Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is

not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

''(3) GRIEVANCE AND INTERNAL APPEALS.—With respect to the grievance system and internal appeals process required to be established under sections 102 and 103 of such Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such system and process (and is not liable for the issuer's failure to provide for such system and process), if the issuer is obligated to provide for (and provides for) such system and process.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 106 of such Act, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections of such Act, the group health plan shall not be liable for such violation unless the plan caused such violation:

''(A) Section 124 (relating to nondiscrimination in delivery of services).

''(B) Section 125 (relating to prohibition of interference with certain medical communications).

''(C) Section 126 (relating to provider incentive plans).

''(D) Section 102(b) (relating to providing medically necessary care).

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle D (and section 113) of title I of the Promoting Responsible Managed Care Act of 1998 in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 713''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 712 the following new item:

''Sec. 713. Patient protection standards.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 144(b))'' after ''part 7''.

(d) REFERENCE TO ENHANCED ENFORCEMENT AUTHORITY.—For provisions providing for enhanced authority to enforce the patient protection requirements of title I under the Employee Retirement Income Security Act of 1974, see section 142.

SEC. 302. ENFORCEMENT FOR ECONOMIC LOSS CAUSED BY COVERAGE DETERMINATIONS.

(a) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 142(a) of this Act, is

amended by redesignating paragraphs (7) and (8) as paragraphs (8) and (9), respectively, and by inserting after paragraph (6) the following new paragraph:

''(7)(A) In any case in which—

''(i) a coverage determination (as defined in section 101(a)(2) of the Promoting Responsible Managed Care Act of 1998) under a group health plan (as defined in section 503(b)(8)) is not made on a timely basis or is made on such a basis but is not made in accordance with the terms of the plan, this title, or title I of such Act, and

''(ii) a participant or beneficiary suffers injury (including loss of life, health, or the ability to regain or maintain maximum function or (in the case of a child under the age of 6) development) as a result of such coverage determination,

any person or persons who are responsible under the terms of the plan for the making of such coverage determination are liable to the aggrieved participant or beneficiary for the amount of the economic loss suffered by the participant or beneficiary caused by such coverage determination. Any question of fact in any cause of action under this paragraph shall be based on the preponderance of the evidence after de novo review.

''(B) For purposes of subparagraph (A), the term 'economic loss' means any pecuniary loss (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities) caused by the coverage determination. Such term does not include punitive damages or damages for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

''(C) Nothing in this paragraph shall be construed as requiring exhaustion of administrative process in the case of severe bodily injury or death.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to coverage determinations made on or after the date of the enactment of this Act.

TITLE IV—PATIENT PROTECTION STANDARDS UNDER THE INTERNAL REVENUE CODE OF 1986

SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (as amended by section 1531(a) of the Taxpayer Relief Act of 1997) is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

"Sec. 9813. Standard relating to patient protection standards."; and

(2) by inserting after section 9812 the following:

"SEC. 9813. STANDARD RELATING TO PATIENT PROTECTION STANDARDS.

"A group health plan shall comply with the requirements of title I of the Promoting Responsible Managed Care Act of 1998 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.".

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 1999 (in this section referred to as

the ''general effective date'') and also shall apply to portions of plan years occurring on and after such date.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreement relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 502. COORDINATION IN IMPLEMENTATION.

Section 104(1) of Health Insurance Portability and Accountability Act of 1996 is amended by striking ''this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, chapter 100 of the Internal Revenue Code of 1986, and title I of the Promoting Responsible Managed Care Act of 1998''.

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